Survey Response Details

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Response Details

Page 1

1) Country

Maldives (0)

2) Name of the National AIDS Committee Officer in charge of NCPI submission and who can be contacted for questions, if any:

Abdul Hameed

3) Postal address:

Centre for Community Health and Disease Control Health Building Sosun Magu Male'. Maldives

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hameed@health.gov.mv

7) Date of submission:

Please enter in DD/MM/YYYY format

31/03/2010

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8) Describe the process used for NCPI data gathering and validation:

Relevant government officials were trained Consultants were hired (data colection and report writing) Working groups were formulated Series of stakeholder meetings were held Verified with available research data

9) Describe the process used for resolving disagreements, if any, with respect to the responses to specific questions:

Disagreements were resolved, through series of meetings and consulting and refering to guidelines, and concerned authorities

10)

Highlight concerns, if any, related to the final NCPI data submitted (such as data quality, potential misinterpretation of questions and the like):

Time constraints Availabiity of data Lack of data for triangulation

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11)

NCPI - PART A [to be administered to government officials]

	Organization	Names/Positions	Respondents to Part A [Indicate which parts each respondent was queried on]
Respondent 1	Center for Community Health and Disease Control (CCHDC) / Ministry of Health & Family	Dr Ahmed Jamsheed Mohamed, Director General	A.I, A.II, A.III, A.IV, A.V

12)

	Organization	Names/Positions	Respondents to Part A [Indicate which parts each respondent was queried on]
Respondent 2	Center for Community Health and Disease Control (CCHDC) / Ministry of Health & Family	Mr. Abdul Hameed, Senior Public Health Programme Officer	A.I, A.II, A.III, A.IV, A.V
Respondent 3	Center for Community Health and Disease Control (CCHDC) / Ministry of Health & Family	Dr. Solah Shareef, Senior Medical Officer	A.I, A.II, A.III, A.IV, A.V
Respondent 4	Indira Gandhi Memorial Hospital	Dr. Ali Nazeem, Consultant in Medicine	A.I, A.IV
Respondent 5	National Blood Transfusion Center	Dr. Aminath Hudha, Senior Registrar in Pathology	A.III
Respondent 6	Ministry of Health & Family	Ms. Aminath Nazviya, Assistant Director	A.I, A.II, A.V
Respondent 7	Department of Drug Prevention and Rehabilitation Services (DDPRS), Ministry of Health & Family	Ms. Aminath Mirfath Ahmed, Programme Manager	A.II, A.IV, A.V
Respondent 8	Department of Drug Prevention and Rehabilitation Services (DDPRS), Ministry of Health & Family	Ms. Aishath Zahira, Behaviour Change Communication Officer	A.II, A.IV, A.V
Respondent 9	Center for Community Health and Disease Control (CCHDC) / Ministry of Health & Family	Mr. Abdulla Adam, Programme Assistant	A.III, A.IV, A.V
Respondent	Center for Community Health and	Ms. Rifua Rasheed,	

Respondent 10	Disease Control (CCHDC) / Ministry of Health & Family	Finance and Reporting Officer	A.III, A.IV, A.V
Respondent 11	Center for Community Health and Disease Control (CCHDC) / Ministry of Health & Family	Ms. Faruzana Ibrahim Manik, Blood Programme Officer	A.III, A.IV, A.V
Respondent 12	Center for Community Health and Disease Control (CCHDC) / Ministry of Health & Family	Mr. Ali Naseer Ibrahim, Blood Programme Officer	A.III, A.IV, A.V
Respondent 13	Center for Community Health and Disease Control (CCHDC) / Ministry of Health & Family	Ms. Mariyam Waheeda, Assistant Programme Officer	A.I, A.II, A.III, A.IV, A.V
Respondent 14			
Respondent 15			
Respondent 16			
Respondent 17			
Respondent 18			
Respondent 19			
Respondent 20			
Respondent 21			
Respondent 22			
Respondent 23			
Respondent 24			
Respondent 25			

13)

NCPI - PART B [to be administered to civil society organizations, bilateral agencies, and UN organizations]

	Organization	Names/Positions	Respondents to Part B [Indicate which parts each respondent was queried on]
Respondent 1	UNDP	Ms. Ivana Lohar, Programme Specialist	B.I, B.II, B.III, B.IV

14)

	Organization	Names/Positions	Respondents to Part B [Indicate which parts each respondent was queried on]
Respondent 2	UNDP	Ms. Aminath Nawal, Programme Monitoring & Evaluation Associate	B.I, B.II, B.III, B.IV
Respondent	UNICEF	Ms. Camelia Olaru Raita, HIV	B.I, B.II, B.III, B.IV

3	UNICEF	Focalpoint	B.I, B.II, B.III, B.IV
Respondent 4	WHO	Dr. Vimlesh Purohit, HIV/AIDS Officer	B.I, B.II, B.III, B.IV
Respondent 5	UNFPA	Ms. Kumiko Yoshida, International Programme Specialist	B.III
Respondent 6	Society for Health Education (SHE)	Ms. Asna Luthfee, Programme Associate	B.II, B.III, B.IV
Respondent 7	Society for Health Education (SHE)	Ms. Thoma Abdul Samad, Counselor	B.II, B.III, B.IV
Respondent 8	Society for Women against Drugs (SWAD)	Ms. Aishath Fareed, Counselor	B.I, B.II, B.III, B.IV
Respondent 9	Society for Women against Drugs (SWAD)	Ms. Aishath Rishtha, Programme Manager	B.I, B.II
Respondent 10	Journey	Mr. Ali Adyb, Public Relations Executive	B.I, B.II, B.III, B.IV
Respondent 11	Journey	Mr. Ahmed Adam, Chair - Interim Committee	B.I, B.II, B.III, B.IV
Respondent 12			
Respondent 13			
Respondent 14			
Respondent 15			
Respondent 16			
Respondent 17			
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Respondent 20			
Respondent 21			
Respondent 22			
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Respondent 25			

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15)

Part A, Section I: STRATEGIC PLAN

1. Has the country developed a national multisectoral strategy to respond to HIV?

(Multisectoral strategies should include, but are not limited to, those developed by Ministries such as the ones listed under 1.2)

Yes (0)

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16) **Part A, Section I: STRATEGIC PLAN**

Question 1 (continued)
Period covered:

2007- 2011

17)

1.1 How long has the country had a multisectoral strategy?

Number of Years

5

18)

1.2 Which sectors are included in the multisectoral strategy with a specific HIV budget for their activities?

	Included in strategy	Earmarked budget
Health	Yes	Yes
Education	Yes	No
Labour	Yes	No
Transportation	Yes	No
Military/Police	Yes	No
Women	Yes	No
Young people	Yes	No
Other*	Yes	No

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19) **Part A, Section I: STRATEGIC PLAN**

Question 1.2 (continued)
If "Other" sectors are included, please specify:

Tourism and Fisheries

20)

IF NO earmarked budget for some or all of the above sectors, explain what funding is used to ensure implementation of their HIV-specific activities?

Following donor funding is available: UNDP, through GFATM for blood safety, HIV prevention for DU/IDU, seafarers, resort workers and migrants, Care and treatment PLWHA UNODC - Drug users UNICEF - young and adolescents (in and out of school youth) UNFPA - women and youth WHO –

Technical support

Page 9

21)

Part A, Section I: STRATEGIC PLAN

1.3 Does the multisectoral strategy address the following target populations, settings and crosscutting issues?

Target populations	
a. Women and girls	Yes
b. Young women/young men	Yes
c. Injecting drug users	Yes
d. Men who have sex with men	Yes
e. Sex workers	Yes
f. Orphans and other vulnerable children	No
g. Other specific vulnerable subpopulations*	Yes
Settings	
h. Workplace	Yes
i. Schools	Yes
j. Prisons	Yes
Cross-cutting issues	
k.HIV and poverty	Yes
l. Human rights protection	Yes
m. Involvement of people living with HIV	Yes
n. Addressing stigma and discrimination	Yes
o. Gender empowerment and/or gender equality	Yes

22)

1.4 Were target populations identified through a needs assessment?

Yes (0)

Page 10

23)

Part A, Section I: STRATEGIC PLAN

Question 1.4 (continued)
IF YES, when was this needs assessment conducted?

Please enter the year in yyyy format

2006

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24)

Part A, Section I: STRATEGIC PLAN

1.5 What are the identified target populations for HIV programmes in the country?

Injecting Drug Users (IDUs), female commercial sex workers, clients of sex workers, MSM and male sex workers , youth, prisoners, migrant workers.

25)

1.6 Does the multisectoral strategy include an operational plan?

Yes (0)

26)

1.7 Does the multisectoral strategy or operational plan include:

a. Formal programme goals?	Yes
b. Clear targets or milestones?	Yes
c. Detailed costs for each programmatic area?	Yes
d. An indication of funding sources to support programme?	Yes
e. A monitoring and evaluation framework?	Yes

27)

1.8 Has the country ensured "full involvement and participation" of civil society* in the development of the multisectoral strategy?

Active involvement (0)

Page 12

28)

Part A, Section I: STRATEGIC PLAN

Question 1.8 (continued)
IF active involvement, briefly explain how this was organised:

During the last year of implementation of NSP 2002-2006 number of opinion leaders , NGOs , HIV professionals raised concern on increase in risk behaviours and commissioned a situation analysis to guide development of new NSP .The report was approved by NAC , members including civil society. Following this a participatory process led by the ministry of health and family ,conducted series of stakeholder meetings involving government , (health and non health ministries) and civil society organizations to develop national strategic plan in 2007, defining strategic priorities, objectives , and major activities. Civil society included were mainly NGOs working with DU, youth and UN agencies.

29)

1.9 Has the multisectoral strategy been endorsed by most external development partners (bi-laterals, multi-laterals)?

Yes (0)

30)

1.10 Have external development partners aligned and harmonized their HIV-related programmes to the national multisectoral strategy?

Yes, all partners (0)

Page 14

31)

Part A, Section I: STRATEGIC PLAN

2. Has the country integrated HIV into its general development plans such as in: (a) National Development Plan; (b) Common Country Assessment / UN Development Assistance Framework; (c) Poverty Reduction Strategy; and (d) sector-wide approach?

Yes (0)

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32)

Part A, Section I: STRATEGIC PLAN

2.1 *IF YES,* in which specific development plan(s) is support for HIV integrated?

a. National Development Plan	Yes
b. Common Country Assessment / UN Development Assistance Framework	Yes
c. Poverty Reduction Strategy	Yes
d. Sector-wide approach	Yes
e. Other: National Blood Policy, Reproductive Health Strategy	Yes

33)

2.2 *IF YES,* which specific HIV-related areas are included in one or more of the development plans?

HIV-related area included in development plan(s)	
HIV prevention	Yes
Treatment for opportunistic infections	Yes
Antiretroviral treatment	Yes
Care and support (including social security or other schemes)	Yes
HIV impact alleviation	Yes
Reduction of gender inequalities as they relate to HIV prevention/treatment, care and/or support	Yes
Reduction of income inequalities as they relate to HIV prevention/treatment, care and/or support	Yes
Reduction of stigma and discrimination	Yes
Women's economic empowerment (e.g. access to credit, access toland, training)	Yes
Other: Please specify	No

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34)

Part A, Section I: STRATEGIC PLAN

3. Has the country evaluated the impact of HIV on its socioeconomic development for planning purposes?

No (0)

Page 17

35)

4. Does the country have a strategy for addressing HIV issues among its national uniformed services (such as military, police, peacekeepers, prison staff, etc)?

Yes (0)

Page 18

36)

Part A, Section I: STRATEGIC PLAN

4.1 *IF YES*, which of the following programmes have been implemented beyond the pilot stage to reach a signifi cant proportion of the uniformed services?

Behavioural change communication	No
Condom provision	No
HIV testing and counselling	Yes
Sexually transmitted infection services	Yes
Antiretroviral treatment	No
Care and support	No
Other: Please specify	No

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37)

Part A, Section I: STRATEGIC PLAN

Question 4.1 (continued)
If HIV testing and counselling *is provided* to uniformed services, briefly describe the approach taken to HIV testing and counselling (e.g, indicate if HIV testing is voluntary or mandatory etc):

Mandatory testing on recruitment and training and scholarships abroad. Also, voluntary testing available.

38)

5. Does the country have non-discrimination laws or regulations which specify protections for most-at-risk populations or other vulnerable subpopulations?

Yes (0)

Page 20

39)

Part A, Section I: STRATEGIC PLAN

5.1 *IF YES,* for which subpopulations?

a. Women	Yes
b. Young people	Yes
c. Injecting drug users	No
d. Men who have sex with men	No
e. Sex Workers	No
f. Prison inmates	No
g. Migrants/mobile populations	No
Other: Please specify	No

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40)

Part A, Section I: STRATEGIC PLAN

6. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for most-at-risk populations or other vulnerable subpopulations?

Yes (0)

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41)

Part A, Section I: STRATEGIC PLAN

6.1 *IF YES,* for which subpopulations?

a. Women	No
b. Young people	No
c. Injecting drug users	Yes
d. Men who have sex with men	Yes
e. Sex Workers	Yes
f. Prison inmates	Yes
g. Migrants/mobile populations	No
Other: Please specify	No

42)

IF YES, briefly describe the content of these laws, regulations or policies:

Drug use – possession and trafficking is illegal, Drug control legislation and legal framework. The principal legislative act of Maldives dealing with narcotic drugs and psychotropic substances is law number 17/77 as amended in 1995 and 2001. The 2001 amendments facilitated confidential interviewing with drug users for the purpose of research. Alcohol is not included in the law on drugs. It is controlled under the law of Islamic Shari'ah. The amended law of 1995 (Section 2 of the law) awards life imprisonment for offences of trafficking of prohibited drugs by either, cultivation, manufacture, exportation, importation, selling, buying, giving or possession for sale of one gram or more of a banned substance. Under section 4 of the law, using or possessing for personal use of less than one gram of a banned substance attracts a penalty of imprisonment, banishment or house arrest for a period between 5 and 12 years, or referral to rehabilitation with the possibility of a suspended legal sentence. For first-time drug offenders, the sentence may be suspended for three years while they undergo rehabilitation under the supervision of NNCB. If an offender undergoes satisfactory rehabilitation and remains within the law for the 3-year period, the suspended sentence is deemed to be fully served and he/she is set free. If on the other hand, the offender is unable to complete this period of rehabilitation successfully, he/she is handed over to the Department of Penitentiary for enforcing the sentence. The Law also allows a drug addict to make a self-submission to the rehabilitation assessment committee of Narcotic Control Board and request for treatment. This opportunity is available for those with no other offences or cases pending against them. Note: Drug Bill has been redrafted and submitted to the Parliament for endorsement. MSM - Male to male sex is illegal in Maldives. According to the Section 15, clause 173 (8a) "Sexual activity with a member of the same sex", under the "Rules of adjudication", the punishment is to be lashed (tha'zeer) between 19 to 39 times and banished or imprisoned for a period between 1 to 3 years, taking into account, the severity of the offence. Migrants- Under (Maldivian Immigration Act), "persons afflicted with a dangerous contagious disease that may be of risk to public health, or considered to have any other dangerous disease" may not have permit to entry. Therefore, anybody applying for a work visa is required to undergo a medical checkup which includes a HIV screening test. However, tourists entering on tourist visa, medical checkups are not required.

43)

Briefly comment on how they pose barriers:

As any sexual activities outside marriage as well as same sex relations is illegal, reaching this population is extremely difficult. In the Maldives its hard to speak about sex industry since sex in return for money or services happens in a non-formal, hidden and inexplicit way. Because of stigma and strong social taboo homosexuality is not a very popular subject among general population. There is lack of pragmatic understanding among public health authorities and law enforcement agencies regarding allowing interventions on prohibited behaviours to occur without police intervention, but without formally legalizing these behaviours. The dialogue between civil society and government is taking place Drug use should be recognised as a health issue, not a criminal act, effective prevention activities for drug users /IDU could be hampered unless a legislative measure is available

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44)

Part A, Section I: STRATEGIC PLAN

7. Has the country followed up on commitments towards universal access made during the High-Level AIDS Review in June 2006?

Yes (0)

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45)

Part A, Section I: STRATEGIC PLAN

7.1 Have the national strategy and national HIV budget been revised accordingly?

Yes (0)

46)

7.2 Have the estimates of the size of the main target populations been updated?

Yes (0)

Page 25

47)

Part A, Section I: STRATEGIC PLAN

7.3 Are there reliable estimates of current needs and of future needs of the number of adults and children requiring antiretroviral therapy?

Estimates of current and future needs (0)

48)

7.4 Is HIV programme coverage being monitored?

Yes (0)

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49)

Part A, Section I: STRATEGIC PLAN

Question 7.4 (continued)
(a) IF YES, is coverage monitored by sex (male, female)?

Yes (0)

50)

(b) IF YES, is coverage monitored by population groups?

Yes (0)

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51)

Part A, Section I: STRATEGIC PLAN

Question 7.4 (b) (continued)
IF YES, for which population groups?

Drug users/IVDU Migrant workers, ANC, PLWHA Youth Briefly explain how this information is used: For planning TI/training NGOs and Ministry of health staff, resource allocation

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52) **Part A, Section I: STRATEGIC PLAN**

Question 7.4 (continued)
(c) Is coverage monitored by geographical area?

Yes (0)

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53)

Part A, Section I: STRATEGIC PLAN

Question 7.4 (c) (continued)
IF YES, at which geographical levels (provincial, district, other)?

Central and Atoll level

54)

7.5 Has the country developed a plan to strengthen health systems, including infrastructure, human resources and capacities, and logistical systems to deliver drugs?

Yes (0)

Page 30

55)

Part A, Section I: STRATEGIC PLAN

Question 7.5 (continued)
Overall, how would you rate strategy planning efforts in the HIV programmes in 2009?

5 (5)

56)

Since 2007, what have been key achievements in this area:

Development of NSP, 2007-2011 with participation of all stakeholders which was costed , and followed by a national action plan and M&E plan

57)

What are remaining challenges in this area:

To align policies and laws /regulations for enabling environment to effective implementation Cultural and religious barriers for MARP interventions especially Harm reduction for IDU.

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58)

Part A, Section II: POLITICAL SUPPORT

1. Do high officials speak publicly and favourably about HIV efforts in major domestic forums at least twice a year?

President/Head of government	Yes
Other high officials	Yes
Other officials in regions and/or districts	Yes

59)

2. Does the country have an officially recognized national multisectoral AIDS coordination body (i.e., a National AIDS Council or equivalent)?

Yes (0)

Page 32

60)

2.1 IF YES, when was it created?

Please enter the year in yyyy format

1987

61)

2.2 IF YES, who is the Chair?

Name	Dr. Aminath Jameel
Position/title	Minister of Health and Family

62)

2.3 IF YES, does the national multisectoral AIDS coordination body:

have terms of reference?	Yes
have active government leadership and participation?	Yes
have a defined membership?	Yes
include civil society representatives?	Yes
include people living with HIV?	No
include the private sector?	Yes
have an action plan?	No
have a functional Secretariat?	Yes
meet at least quarterly?	No
review actions on policy decisions regularly?	Yes
actively promote policy decisions?	Yes

provide opportunity for civil society to influence decision-making?	Yes
strengthen donor coordination to avoid parallel funding and duplication of effort in programming and reporting?	No

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63)

Part A, Section II: POLITICAL SUPPORT

Question 2.3 (continued)
If you answer "yes" to the question "does the National multisectoral AIDS coordination body have a defined membership", how many members?

Please enter an integer greater than or equal to 1

25

64)

If you answer "yes" to the question "does the National multisectoral AIDS coordination body include civil society representatives", how many?

Please enter an integer greater than or equal to 1

3

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65)

Part A, Section II: POLITICAL SUPPORT

3. Does the country have a mechanism to promote interaction between government, civil society organizations, and the private sector for implementing HIV strategies/programmes?

Yes (0)

Page 35

66)

Part A, Section II: POLITICAL SUPPORT

Question 3 (continued)
IF YES, briefly describe the main achievements:

NAC and the CCM have members representing government ,civil society and the private sector which promotes interaction between the implementing partners, Government, NGOs and UN agencies. The National strategic plan and policy statement clearly mentions involvement of civil society and private sector in planning strategies and implementing the programmes The round 6 GFATM HIV proposal is implemented through a project with the, partnership of government (NAP) NGOs and the UNDP to address blood safety , interventions for IVDU and programs for seafarers, resort workers and migrants. Also, NAP organizes regular coordination meetings, attended by representatives from government, UN and civil society

67)

Briefly describe the main challenges:

Few NGOs to address MARP interventions , and lack technical capacity , none for MSM/Sex workers As the NAC is a hierarchy level body, regular meetings to coordinate activities is not practical. There are no subcommittee of NAC to coordinate the specific key strategic areas IE. Surveillance, legal and ethical prevention including IEC , for care and support for PLWHA, monitoring & evaluation including research etc. To have a skilled person/S as Program focal points with specific TORs in the ministry/NAP for each area for better coordination and accountability Frequent change /transfer of skilled staff hampering continuity of work

68)

4. What percentage of the national HIV budget was spent on activities implemented by civil society in the past year?

Please enter the rounded percentage (0-100)

0

69)

5. What kind of support does the National AIDS Commission (or equivalent) provide to civil society organizations for the implementation of HIV-related activities?

Information on priority needs	Yes
Technical guidance	Yes
Procurement and distribution of drugs or other supplies	Yes
Coordination with other implementing partners	Yes
Capacity-building	Yes
Other: Please specify	No

70)

6. Has the country reviewed national policies and laws to determine which, if any, are inconsistent with the National AIDS Control policies?

No (0)

Page 38

71)

Part A, Section II: POLITICAL SUPPORT

Question 6.1 (continued)
Overall, how would you rate the political support for the HIV programmes in 2009?

3 (3)

72)

What are remaining challenges in this area:

Lack of conducive environment for NAP and other partners to implement interventions for MARP

with trust and security.

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73)

Part A, Section III: PREVENTION

1. Does the country have a policy or strategy that promotes information, education and communication (IEC) on HIV to the *general population*?

Yes (0)

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74)

Part A, Section III: PREVENTION

1.1 IF YES, what key messages are explicitly promoted?

Check for key message explicitly promoted (multiple options allowed)

a. Be sexually abstinent (0)
b. Delay sexual debut (0)
c. Be faithful (0)
d. Reduce the number of sexual partners (0)
e. Use condoms consistently (0)
f. Engage in safe(r) sex (0)
g. Avoid commercial sex (0)
h. Abstain from injecting drugs (0)
j. Fight against violence against women (0)
k. Greater acceptance and involvement of people living with HIV (0)
l. Greater involvement of men in reproductive health programmes (0)
n. Know your HIV status (0)
o. Prevent mother-to-child transmission of HIV (0)

75)

1.2 In the last year, did the country implement an activity or programme to promote accurate reporting on HIV by the media?

Yes (0)

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76)

Part A, Section III: PREVENTION

2. Does the country have a policy or strategy promoting HIV-related reproductive and sexual health education for young people?

Yes (0)

77)

2.1 Is HIV education part of the curriculum in:

primary schools?	No
secondary schools?	Yes
teacher training?	Yes

78)

2.2 Does the strategy/curriculum provide the same reproductive and sexual health education for young men and young women?

Yes (0)

79)

2.3 Does the country have an HIV education strategy for out-of-school young people?

Yes (0)

80)

3. Does the country have a policy or strategy to promote information, education and communication and other preventive health interventions for most-at-risk or other vulnerable sub-populations?

Yes (0)

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81)

3.1 IF YES, which populations and what elements of HIV prevention do the policy/strategy address?

Check which specific populations and elements are included in the policy/strategy

Targeted information on risk reduction and HIV education	Injecting drug user, Men having sex with men, Sex workers, Clients of sex workers, Prison inmates, Other populations

Stigma and discrimination reduction	Injecting drug user, Men having sex with men, Sex workers, Clients of sex workers, Prison inmates, Other populations
Condom promotion	Injecting drug user, Men having sex with men, Sex workers, Clients of sex workers, Other populations
HIV testing and counselling	Injecting drug user, Men having sex with men, Sex workers, Clients of sex workers, Prison inmates, Other populations
Reproductive health, including sexually transmitted infections prevention and treatment	Injecting drug user, Men having sex with men, Sex workers, Clients of sex workers, Prison inmates, Other populations
Vulnerability reduction (e.g. income generation)	
Drug substitution therapy	Injecting drug user
Needle & syringe exchange	

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82) **Part A, III. PREVENTION**

Question 3.1 (continued)

You have checked one or more policy/strategy for "Other populations". Please specify what are "other populations".

Targeted information on risk reduction and HIV education - migrant workers police, resort workers , seafarers

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83)

Part A, III. PREVENTION

Question 3.1 (continued)

Overall, how would you rate the policy efforts in support of HIV prevention in 2009?

9 (9)

84)

Since 2007, what have been key achievements in this area:

Sensitization, exposure visits and trainings for law enforcement officers and policy makers on drug and HIV/AIDS has been conducted by UNDP and Civil society. As a result the issue of HIV was addressed in the sermons (nation-wide) of the 2 Friday prayers and 7 sessions on the HIV and the preventative behaviours within the Islamic context was delivered in 7 mosques. A sensitization on HIV was also held for the Islamic scholars in partnership with the Ministry of Islamic Affairs. BBS conducted in 2008 generated very rich information on MARPs especially injecting drug users and also on the vulnerable populations. This information helped the civil society to design and implement more effective interventions

85)

What are remaining challenges in this area:

Establishing rules and regulation which will allow the government to conduct prevention programmes especially for MARPs. Political commitment and focus from health and other ministries in the formulation of a National AIDS policy to address above issues in the context of

very few numbers of PLWHA and hidden nature of the HIV situation

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86)

Part A, III. PREVENTION

4. Has the country identified specific needs for HIV prevention programmes?

Yes (0)

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87)

Part A, III. PREVENTION

Question 4 (continued)
IF YES, how were these specific needs determined?

Situation analysis of HIV/AIDS in Maldives in 2006- A rapid need assessments was done in the 2006, and this was followed by a BBS in 2008 to check the risk behaviours of the most of risk population and youth. A joint mid term review in 2009 has reviewed the implementation of the National Strategic plan which identified gaps and gave directions for Strengthening and scaling up of the implementation of NSP 2007-2011

88)

4.1 To what extent has HIV prevention been implemented?

	The majority of people in need have access
HIV prevention component	
Blood safety	Agree
Universal precautions in health care settings	Agree
Prevention of mother-to-child transmission of HIV	Agree
IEC* on risk reduction	Agree
IEC* on stigma and discrimination reduction	Don't agree
Condom promotion	Don't agree
HIV testing and counselling	Agree
Harm reduction for injecting drug users	N/A
Risk reduction for men who have sex with men	Don't agree
Risk reduction for sex workers	Don't agree
Reproductive health services including sexually transmitted infections prevention and treatment	Agree
School-based HIV education for young people	Don't agree
HIV prevention for out-of-school young people	Don't agree
HIV prevention in the workplace	Don't agree
Other: please specify	N/A

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89)

Part A, III. PREVENTION

Overall, how would you rate the efforts in the implementation of HIV prevention programmes in 2009?

3 (3)

90)

Since 2007, what have been key achievements in this area:

-In 2008, the first Bio-Behavioural Survey (BBS) was conducted in the Maldives (Corpuz AC, October 2008). A total of 1,791 serologic samples were taken across five groups: female sex workers (FSW), men who have sex with men (MSM), injecting drug users (IDU), occupational cohorts of men (OCM – including seafarers, construction workers and resort workers) and youth, across Male', Addu and Laamu atolls. The BBS highlighted alarming HIV and STI risky behaviour (sexual intercourses without protection as well as drug injecting by sharing needles and syringes) among population calling for action for prioritisation of the national response based on new evidence. Based on the BBS's findings, NSP identified the strategies for HIV prevention for some of the vulnerable population (migrant workers). During 2008-2009, the interventions for migrant workers consisted in distribution of IEC materials, peer education sessions, condom promotion and distribution, STI prevention, counselling and testing. The GFATM round 6 grant for 2007-2012 address prevention interventions for IDU, youth and other vulnerable populations (seafarers, migrants),blood safety and prevention of HIV in health care setting (PEP, universal precautions). Already phase one is completed IDUs even before detecting the first case of IDU related HIV infection , prevention efforts started, and with a broad level of support for intervention by (Government, NGO, Donors & UN agencies, prevention focusing IVDU scaled up however focus mainly on male IDU as women IDU are low. Provision of number of new interventions , including after care services and outreach (IEC) addressing safe injecting via NGOs –Journey, SWAD,SHE - Political commitment - A statement on HIV is included in the political manifesto in 2009 -education on cleaning needle/syringe for reuse - Promoting VCT for HIV through the VCT centers While Journey offers HIV testing on site , SHE /SWAD promotes IDUs to attend Journey and public VCT centers -Pilot project for oral substitution therapy-with methadone commenced in Male the commercial hub in 2009 – - A new detoxification centre opened in Villangi in 2009 - UN agencies supported aftercare services including psychosocial care and parental counselling services for ex - drug addicts through "Journey past 3 yrs - Government run 2 rehabilitation centers in Male and ADDU –providing residential care using " therapeutic education community model - Current GFATM funded project aims at reaching 1200 IDU with peer education 2007-2011, already 77 peer educators were trained, and 1841 IDU reached with IEC as end Feb 2009 - A mapping exercise is planned – to be conducted early 2010 including iDU,MSM and sex workers which will facilitate planning implementation of TI aimed at MARP and budgeting – - In prisons limited IEC activity is conducted limited, discussion ongoing to introduce a comprehensive harm reduction package with the support of police and Ministry of home affairs official -National drug bill – to address DU/IDU as a health issue than a criminal act will pave the way for creating - enabling environment for DU interventions In 2009 , and 105 law enforcement officers and police were - trained in HIV and IDU issues -100% screening of donated blood to ensure blood safety - screening of pregnant mothers with informed consent-for PMTCT

91)

What are remaining challenges in this area:

- The 2 priority strategic areas of NSP which is not addressed through GFATM round 6 Need

attention. Interventions for key populations , and building capacity NAP - plan delivery of comprehensive prevention interventions and implement programmes for MSM , sex workers and Identify budget - Political commitment and create and enabling environment to address MSM and sex workers - as BBS has shown existence of large number of MARP (very hidden and) with high HIV risk behaviours denial that it does not exist and no civil society organisations or members of high risk populations to implement TI - Introducing comprehensive harm reduction programme for IDUs including needle exchange programs as and when needed -Capacity build NGOs on implementation - build NAP staff in programme management skills and technical skills for implementation -Reporting systems of STIs (Syndromic management) , need strengthening to capture early warning of an impending HIV epidemic -Syndromic management of STIs especially among MARP to be strengthened as there are no special STI clinics for MARP - Condom promotion among risk groups as well as unmarried youth - Increase VCT uptake by MARP as accessibility is an issue with the distribution of MARP in several Atolls./regions – Gender issues and overcoming cultural /religious barriers for promoting condoms, addressing womens issues no specific programmes for women IDUs -creating enabling environment for government and NGOs to carry out research /surveys and interventions in prisons

Page 48

92)

Part A, Section IV: TREATMENT, CARE AND SUPPORT

1. Does the country have a policy or strategy to promote comprehensive HIV treatment, care and support? (Comprehensive care includes, but is not limited to, treatment, HIV testing and counselling, psychosocial care, and home and community-based care).

Yes (0)

Page 49

93)

Part A, Section IV: TREATMENT, CARE AND SUPPORT

1.1 IF YES, does it address barriers for women?

Yes (0)

94)

1.2 IF YES, does it address barriers for most-at-risk populations?

Yes (0)

95)

2. Has the country identified the specific needs for HIV treatment, care and support services?

No (0)

Page 50

96)

IF NO, how are HIV treatment, care and support services being scaled-up?

Maldives is a low prevalence country and the ART program was commenced in 2004. 100 % coverage in ART needs. ART is provided in a single center, and no specific care and support systems planned. Scaling up is not planned at this stage due to the nature of the epidemic. Currently services are planned based on program records on number of PLWHA detected on screening , socio demographic data including gender, number on ART, and deaths If the needs are the estimation of burden of PLWHA and how many adult and children need ART and for PMTCT, Co-trim prophylaxis data is available with NAP from estimations and projections

97)

2.1 To what extent have the following HIV treatment, care and support services been implemented?

	The majority of people in need have access
HIV treatment, care and support service	
Antiretroviral therapy	Agree
Nutritional care	Don't agree
Paediatric AIDS treatment	N/A
Sexually transmitted infection management	Agree
Psychosocial support for people living with HIV and their families	Agree
Home-based care	Don't agree
Palliative care and treatment of common HIV-related infections	Don't agree
HIV testing and counselling for TB patients	Don't agree
TB screening for HIV-infected people	Agree
TB preventive therapy for HIV-infected people	Agree
TB infection control in HIV treatment and care facilities	Agree
Cotrimoxazole prophylaxis in HIV-infected people	Agree
Post-exposure prophylaxis (e.g. occupational exposures to HIV, rape)	Agree
HIV treatment services in the workplace or treatment referral systems through the workplace	N/A
HIV care and support in the workplace (including alternative working arrangements)	Don't agree
Other: please specify	

Page 51

98)

Part A, Section IV: TREATMENT, CARE AND SUPPORT

3. Does the country have a policy for developing/using generic drugs or parallel importing of drugs for HIV?

Yes (0)

99)

4. Does the country have access to *regional* procurement and supply management mechanisms for critical commodities, such as antiretroviral therapy drugs, condoms, and substitution drugs?

Yes (0)

Page 52

100)

Part A, Section IV: TREATMENT, CARE AND SUPPORT

Question 4 (continued)
IF YES, for which commodities?:

ARV, Condoms, substitution drugs

Page 53

101)

Part A, Section IV: TREATMENT, CARE AND SUPPORT

Overall, how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2009?

4 (4)

102)

Since 2007, what have been key achievements in this area:

- timely procurement and distribution of ARV drugs

103)

What are remaining challenges in this area:

- To optimize utilisation of the VCT centers in public (8 at present) and 2 stand alone VCT centers. (Majority of HIV tests are mandatory for pre-employment screening, ANC and blood donor screening or pre-surgical screening and PIT without proper counselling) -To develop a standardized recording and reporting formats for PLWHA under care. At present socio demographic data , are recorded at NAP upon entry but limited clinical details to monitor adherence , drug resistance and quality of care are recorded. - As the number of PLWHA are few , increasing ART centres to increase accessibility is not justified, at Atoll or provincial level However follow up of patients for monitoring ART drug resistance, adherence and compliance to treatment , partner screening and positive prevention of discordant couples is of concern in the future due to the wide geographical distribution of PLWHA. -In the region majority of married women (monogamous) are infected through their husbands ,thus gender sensitive issues such as partner disclosure, inheritance of property rights may be a concern. - For PMTCT programmes to address the first and second prongs of preventing HIV infection among young girls, contraception services , should be given more attention as screening of pregnant women is not cost effective in low prevalence situation. -NGOs or PLWHA organisations to support community and home based care for PLWHA is a challenge due to small numbers for fear of breach of confidentiality . - Capacity building of clinicians to diagnose HIV infection early and provision of quality care and ART -Reduce stigma and discrimination of PLWHA in health care settings

Page 54

104)

Part A, Section IV: TREATMENT, CARE AND SUPPORT

5. Does the country have a policy or strategy to address the additional HIV-related needs of orphans and other vulnerable children?

No (0)

Page 57

105)

Part A, Section V: MONITORING AND EVALUATION

1. Does the country have *one* national Monitoring and Evaluation (M&E) plan?

Yes (0)

Page 58

106)

1.1 IF YES, years covered:
Please enter the start year in yyyy format below

2007

107)

1.1 IF YES, years covered:
Please enter the end year in yyyy format below

2011

108)

1.2 IF YES, was the M&E plan endorsed by key partners in M&E?

Yes (0)

109)

1.3 IF YES, was the M&E plan developed in consultation with civil society, including people living with HIV?

No (0)

110)

1.4 IF YES, have key partners aligned and harmonized their M&E requirements (including indicators) with the national M&E plan?

Yes, most partners (0)

Page 60

111)

Part A, Section V: MONITORING AND EVALUATION

2. Does the national Monitoring and Evaluation plan include?

a data collection strategy	Yes
a well-defined standardised set of indicators	Yes
guidelines on tools for data collection	Yes
a strategy for assessing data quality (i.e., validity, reliability)	Yes
a data analysis strategy	Yes
a data dissemination and use strategy	Yes

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112)

Part A, Section V: MONITORING AND EVALUATION

Question 2 (continued)
If you check "YES" indicating the national M&E plan include a data collection strategy, then does this data collection strategy address:

routine programme monitoring	Yes
behavioural surveys	Yes
HIV surveillance	Yes
Evaluation / research studies	Yes

113)

3. Is there a budget for implementation of the M&E plan?

In progress (0)

Page 64

114)

4. Are M&E priorities determined through a national M&E system assessment?

Yes (0)

Page 65

115)

Part A, Section V: MONITORING AND EVALUATION

Question 4 (continued)
IF YES, briefly describe how often a national M&E assessment is conducted and what the assessment involves:

An assessment of M&E system of the NSP and NAP was conducted in 2009 using Monitoring &

Evaluation System Strengthening Toolkit (MESST). An external review of national response is essential prior to development of next NSP. UNDP continues to monitor the M&E activities.

116)

5. Is there a functional national M&E Unit?

No (0)

Page 66

117)

Part A, Section V: MONITORING AND EVALUATION

Question 5 (continued)
IF NO, what are the main obstacles to establishing a functional M&E Unit?

Currently there is no funding available to establish a unit. Capacity and skill is needed to be enhanced in this area.

Page 70

118)

Part A, Section V: MONITORING AND EVALUATION

6. Is there a national M&E Committee or Working Group that meets regularly to coordinate M&E activities?

No (0)

119)

6.1 Does it include representation from civil society?

No (0)

Page 71

120)

7. Is there a central national database with HIV- related data?

Yes (0)

Page 72

121)

Part A, Section V: MONITORING AND EVALUATION

7.1 IF YES , briefly describe the national database and who manages it:

NAP is responsible for ensuring collection, compilation, analysis and dissemination of HIV/STI data regular basis ensuring quality , relevant and accurate.This will be fed in to the computerised national Health information system in the MOHF(CCHDC).

122)

7.2 IF YES, does it include information about the content, target populations and geographical coverage of HIV services, as well as their implementing organizations?

Yes, all of the above (0)

Page 73

123)

7.3 Is there a functional* Health Information System?

At national level	Yes
At subnational level	Yes

Page 74

124) **Part A, Section V: MONITORING AND EVALUATION**

For Question 7.2, you have checked "Yes, but only some of the above", please specify what the central database has included.

For Question 7.3, you have indicated "Yes" to "subnational level", please specify at what level(s)?

Atoll and island level

125)

8. Does the country publish at least once a year an M&E report on HIV, including HIV surveillance data?

No (0)

126)

9. To what extent are M&E data used

9.1 in developing / revising the national AIDS strategy?:

1 (1)

127)

Provide a specific example:

• The 2006 situation analysis data was used to revise the 2002-2006 strategy and a new NSP 2007-2011 developed more focus on MARP • BBS in 2008 and Joint review of national response in 2009 , helped the donors and NAP to focus on gaps –Interventions for MARPs, capacity building of NGOs for implementation & NAP skills to plan and administer the National response including M&E m need for revising the NSP 2010-2011

128)

What are the main challenges, if any?

- Convincing policymakers to increase political commitment - To educate religious leaders to overcome denial and lack of interest

Page 75

129) **Part A, Section V: MONITORING AND EVALUATION**

9.2 To what extent are M&E data used for resource allocation?

3 (3)

130)

Provide a specific example:

The size of the population and the risks of HIV transmission was taken into prioritisation and allocating resources esp. for MARP interventions such as human resource needs , capacity building, procurement of commodities (condoms, ART, OST)and tests etc

Page 76

131)

Part A, Section V: MONITORING AND EVALUATION

9.3 To what extent are M&E data used for programme improvement?:

3 (3)

132)

Provide a specific example:

The evidence from BBS - increasing risk behaviours (re-using needles & sharing among IV drug users) and low reach with HIV prevention programmes for IDU, led to re-plan increase coverage with BCC and opening more service delivery points.

133)

What are the main challenges, if any?

- Lack of enabling environment - Lack of human resource - NGOs working with MARP

Page 77

134) **Part A, Section V: MONITORING AND EVALUATION**

10. Is there a plan for increasing human capacity in M&E at national, subnational and service-delivery levels?:

Yes, at all levels (0)

Page 78

135)

10.1 In the last year, was training in M&E conducted

At national level?	Yes
At subnational level?	No
At service delivery level including civil society?	Yes

Page 79

136) **Part A, Section V: MONITORING AND EVALUATION**

Question 10.1 (continued)
Please enter the number of people trained <u>at national level.</u>

Please enter an integer greater than 0

4

137) **Please enter the number of people trained <u>at service delivery level including civil society.</u>**

Please enter an integer greater than 0

3

Page 80

138)

Part A, Section V: MONITORING AND EVALUATION

10.2 Were other M&E capacity-building activities conducted other than training?

Yes (0)

Page 81

139) **Part A, Section V: MONITORING AND EVALUATION**

Question 10.2 (continued)
IF YES, describe what types of activities:

Monitoring & Evaluation System Strengthening Tool workshop, In-country TA to provide M&E training

Page 82

140) **Part A, Section V: MONITORING AND EVALUATION**

Question 10.2 (continued)

Overall, how would you rate the M&E efforts of the HIV programme in 2009?

1 (1)

141)

Since 2007, what have been key achievements in this area:

Review of National M&E system in 2009 Development of National M&E plan in 2009

142)

What are remaining challenges in this area:

Lack of resources (funds and human resources)and capacity to strengthen and operationalize the M&E Plan

Page 83

143)

Part B, Section I: HUMAN RIGHTS

1. Does the country have laws and regulations that protect people living with HIV against discrimination? (including both general non-discrimination provisions and provisions that specifi cally mention HIV, focus on schooling, housing, employment, health care etc.)

No (0)

Page 84

144)

2. Does the country have non-discrimination laws or regulations which specify protections for most-at-risk populations and other vulnerable subpopulations?

No (0)

Page 86

145)

Part B, Section I. HUMAN RIGHTS

3. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for most-at-risk populations and other vulnerable subpopulations?

Yes (0)

Page 87

146)

Part B, Section I. HUMAN RIGHTS

3.1 *IF YES,* for which subpopulations?

a. Women	No
b. Young people	No
c. Injecting drug users	Yes
d. Men who have sex with men	Yes
e. Sex Workers	Yes
f. prison inmates	No
g. Migrants/mobile populations	No
Other: Please specify	

147)

IF YES, briefly describe the content of these laws, regulations or policies:

Drug use – possession and trafficking is illegal, Drug control legislation and legal framework.The principal legislative act of Maldives dealing with narcotic drugs and psychotropic substances is law number 17/77 as amended in 1995 and 2001. The 2001 amendments facilitated confidential interviewing with drug users for the purpose of research. Alcohol is not included in the law on drugs. It is controlled under the law of Islamic Shari'ah. The amended law of 1995 (Section 2 of the law) awards life imprisonment for offences of trafficking of prohibited drugs by either, cultivation, manufacture, exportation, importation, selling, buying, giving or possession for sale of one gram or more of a banned substance. Under section 4 of the law, using or possessing for personal use of less than one gram of a banned substance attracts a penalty of imprisonment, banishment or house arrest for a period between 5 and 12 years, or referral to rehabilitation with the possibility of a suspended legal sentence. For first-time drug offenders, the sentence may be suspended for three years while they undergo rehabilitation under the supervision of NNCB. If an offender undergoes satisfactory rehabilitation and remains within the law for the 3-year period, the suspended sentence is deemed to be fully served and he/she is set free. If on the other hand, the offender is unable to complete this period of rehabilitation successfully, he/she is handed over to the Department of Penitentiary for enforcing the sentence. The Law also allows a drug addict to make a self-submission to the rehabilitation assessment committee of Narcotic Control Board and request for treatment. This opportunity is available for those with no other offences or cases pending against them. Note: Drug Bill has been redrafted and submitted to the Parliament for endorsement. MSM - Male to male sex is illegal in Maldives. According to the Section 15, clause 173 (8a) "Sexual activity with a member of the same sex", under the "Rules of adjudication", the punishment is to be lashed (tha'zeer) between 19 to 39 times and banished or imprisoned for a period between 1 to 3 years, taking into account, the severity of the offence. Migrants- Under (Maldivian Immigration Act), "persons afflicted with a dangerous contagious disease that may be of risk to public health, or considered to have any other dangerous disease" may not have permit to entry. Therefore, anybody applying for a work visa is required to undergo a medical checkup which includes a HIV screening test. However, tourists entering on tourist visa, medical checkup is not required.

148)

Briefly comment on how they pose barriers:

There are no explicit laws, regulations or policies that become obstacles to effective HIV prevention, treatment, care & support for most at risk populations and other vulnerable

subpopulations. However, since Maldives is a Muslim country there are barriers that stem from the religious beliefs, making it t difficult to talk about existence of sexual activity that take place in the country. As any sexual activities outside marriage as well as same sex relations are illegal, reaching this population is extremely difficult. In the Maldives is hard to speak about sex industry since sex in return for money or services happens in a non-formal, hidden and inexplicit way. Because of stigma and strong social taboo homosexuality is not a very popular subject among general population. There is lack of pragmatic understanding among public health authorities and law enforcement agencies regarding allowing interventions on forbidden behaviours to occur without police harassment but without formally legalizing these behaviours. The dialogue about improving the environment (policy, laws, and regulations) and making welcome for HIV preventions among MARPs between civil society and government is taking place. Drug prevention programmes include aftercare activities as well as OST services. However OST are not widely promoted. Premarital and extramarital sex is illegal and only married couples have access to condoms through family planning services. For unmarried youth couples this choice is not available due to the low in the country and this affects the prevention interventions designed for young. However, the condoms are available for everyone from pharmacies.

Page 88

149) **Part B, Section I. HUMAN RIGHTS**

4. Is the promotion and protection of human rights explicitly mentioned in any HIV policy or strategy?

Yes (0)

Page 89

150)

Part B, Section I. HUMAN RIGHTS

Question 4 (continued)
IF YES, briefly describe how human rights are mentioned in this HIV policy or strategy:

The strategy addresses the human rights issue in a very broader context. The strategy is in line with the policy plan statement.

151)

5. Is there a mechanism to record, document and address cases of discrimination experienced by people living with HIV, most-at-risk populations and/or other vulnerable subpopulations?

No (0)

Page 90

152)

6. Has the Government, through political and fi nancial support, involved people living with HIV, most-at-risk populations and/or other vulnerable subpopulations in governmental HIV-policy design and programme implementation?

Yes (0)

Page 91

153)

Part B, Section I. HUMAN RIGHTS

Question 6 (continued)
IF YES, describe some examples:

The National Strategic Plan (NSP) for National AIDS Programme (NAP) was developed with involvement from the NGOs working with/members of drug user's organisation. The proposal for Global Fund Round 6 was prepared by the CCM, which has 22 members (41% government, 39% NGOs and UN agencies). "Journey" a NGO formed mostly by ex drug users along with two other NGOs – Society for Women Against Drugs (SWAD) and Society for Health Education (SHE) are involved in implementation of prevention interventions targeted at DU, IDU and families since 2007 providing aftercare services, out reach (IEC) and counselling. They are Sub recipient of GF grant. The governmental institutions are leading the treatment and rehabilitation services (one Methadone Clinic, two detoxification and one rehabilitation centre). UN agencies (UNICEF, UNDP, WHO, UNODC) and American Embassy collaborates with the government in programme implementation.

154)

7. Does the country have a policy of free services for the following:

a. HIV prevention services	Yes
b. Antiretroviral treatment	Yes
c. HIV-related care and support interventions	Yes

Page 92

155)

Part B, Section I. HUMAN RIGHTS

Question 7 (continued)
IF YES, given resource constraints, briefly describe what steps are in place to implement these policies and include information on any restrictions or barriers to access for different populations:

There is no policy in place regarding free access for different category to public services. For each and every HIV positive Maldivian the treatment (ARV) is free of charge provide by the Ministry of Health and Family (MoHF), via NAP. The treatment is provide by the Government from own resources and is not donor dependent. As the numbers of PLWHA are very few currently, sustainability of provision of ART programme is not an issue. The three sub recipients, of the Global Fund financed project are implementing to address 5 strategic areas of NSP including: • prevention interventions for MARP and other vulnerable populations, • strengthening prevention and control of STIs, blood safety • prevention of HIV in health care settings, • strengthen health system capacity for quality care, support and treatment for PLWHA and strategic information system. • strengthening multisectoral response through capacity building of NGOs will support implementation of the programmes. However care and support interventions are limited due to the few HIV positive cases. The number of prevention services are limited due to constrains: •

Resources constrains within Government and NGOs - human resources (limited number of human resources; limited knowledge/skills about HIV prevention intervention especially for MARYPs; frequent change of experienced and skilled staff) - accessibility (the inhabited islands are spread and there is limited access) - funds (the Government as well as the NGOs don't have the necessary capacity to absorb the available funds) Additionally, in terms of constrains, cultural and religious barriers play a major role in designing effective interventions for MARP. The Sahria law and the cultural barriers need to be addressed in the future, which impede effective interventions for MARP with better advocacy.

156)

8. Does the country have a policy to ensure equal access for women and men to HIV prevention, treatment, care and support?

Yes (0)

Page 93

157)

Part B, Section I. HUMAN RIGHTS

8.1 In particular, does the country have a policy to ensure access to HIV prevention, treatment, care and support for women outside the context of pregnancy and childbirth?

No (0)

158)

9. Does the country have a policy to ensure equal access for most-at-risk populations and/or other vulnerable subpopulations to HIV prevention, treatment, care and support?

Yes (0)

Page 94

159)

Part B, Section I. HUMAN RIGHTS

Question 9 (continued)
IF YES, briefly describe the content of this policy:

The country has a NSP which identifies the need for adequate services for MARPS. As a part of enhancing the access, for testing and prevention in MARPs, there has been recommendations in the VCT guidelines to undertake provider initiated testing for the people who belong to vulnerable groups , as well as the facilities have been extended to the IDU population through the NGO catering to the needs of active as well as recovering addicts.

160)

9.1 IF YES, does this policy include different types of approaches to ensure equal access for different most-at-risk populations and/or other vulnerable sub-populations?

No (0)

Page 95

161)

10.Does the country have a policy prohibiting HIV screening for general employment purposes (recruitment, assignment/relocation, appointment, promotion, termination)?

No (0)

162)

11.Does the country have a policy to ensure that HIV research protocols involving human subjects are reviewed and approved by a national/local ethical review committee?

Yes (0)

Page 96

163)

Part B, Section I. HUMAN RIGHTS

11.1 IF YES, does the ethical review committee include representatives of civil society including people living with HIV?

No (0)

164)

IF YES, describe the approach and effectiveness of this review committee:

There is a national research committee (National Health Research Committee - NHRC). The Civil Society is aware of this committee and has been submitting proposal to this committee. The committee is in a phase of strengthening itself by inviting and increasing the representation from Civil Society.

Page 97

165)

– Existence of independent national institutions for the promotion and protection of human rights, including human rights commissions, law reform commissions, watchdogs, and ombudspersons which consider HIV-related issues within their work

No (0)

166)

– Focal points within governmental health and other departments to monitor HIV-related human rights abuses and HIV-related discrimination in areas such as housing and employment

No (0)

167)

– Performance indicators or benchmarks for compliance with human rights standards in the context of HIV efforts

No (0)

Page 99

168)

Part B, Section I. HUMAN RIGHTS

13. In the last 2 years, have members of the judiciary (including labour courts/ employment tribunals) been trained/sensitized to HIV and human rights issues that may come up in the context of their work?

No (0)

169)

– Legal aid systems for HIV casework

No (0)

170)

– Private sector law firms or university-based centres to provide free or reduced-cost legal services to people living with HIV

No (0)

171)

– Programmes to educate, raise awareness among people living with HIV concerning their rights

No (0)

172)

15. Are there programmes in place to reduce HIV-related stigma and discrimination?

Yes (0)

Page 100

173)

Part B, Section I. HUMAN RIGHTS

Question 15 (continued)
IF YES, what types of programmes?

Media
School education

Personalities regularly speaking out

Other: Workplace STI and HIV Educational sessions Yes

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174)

Part B, Section I. HUMAN RIGHTS

Question 15 (continued)
Overall, how would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV in 2009?

3 (3)

175)

Since 2007, what have been key achievements in this area:

- New drug bill drafted and submitted to the Parliament for endorsement. - Sensitising law enforcement officers on HIV issues on training programmes by UNDP - Civil society and parliamentarians have begun to have a dialogue on drug and HIV/AIDS issue - NSP and action plan to address advocacy - BBS conducted in 2008 generated very reach information on MARP especially youth. This information helped the civil society to design and implement more effective interventions. - BCC strategy developed

176)

What are remaining challenges in this area:

- Political commitment and focus from health and other ministries in the formulation of a National AIDS policy to address above issues in the context of very few numbers of PLWHA and hidden nature of the HIV situation - Establishing rules and regulation who will allow the GOV to conduct prevention programmes especially for MARP.

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177)

Part B, Section II: CIVIL SOCIETY* PARTICIPATION

1. To what extent has civil society contributed to strengthening the political commitment of top leaders and national strategy/policy formulations?

2 (2)

178)

Comments and examples:

In 2009, civil society was involved in the advocacy activities among policy makers. In addition, Department of Drug Prevention and Rehabilitation Services (DDPRS) through UNDP (PR for GF in Maldives) conducted some sensitization sessions among parliamentarians about the HIV/AIDS situation and Drug Bill. This bill does not cover the HIV/AIDS topic.

Page 104

179)

Part B, Section II. CIVIL SOCIETY PARTICIPATION

2. To what extent have civil society representatives been involved in the planning and budgeting process for the National Strategic Plan on HIV or for the most current activity plan (e.g. attending planning meetings and reviewing drafts)?

3 (3)

180)

Comments and examples:

The representatives of the NGOs, civil society and UN agencies were involved in the planning and budgeting process. Due to the lack of knowledge among civil society, most of the time the technical assistance comes from the specialists from the UN system.

Page 105

181)

a. the national AIDS strategy?

3 (3)

182)

b. the national AIDS budget?

3 (3)

183)

c. national AIDS reports?

1 (1)

184)

Comments and examples:

There are only few NGOs (Journey, Society for Health Education-SHE, and Society for Women Against AIDS-SWAD, Open Hand) active in drug prevention intervention, which is linked with HIV prevention information.

Page 106

185)

a. developing the national M&E plan?

2 (2)

186)

b. participating in the national M&E committee / working group responsible for coordination of M&E activities?

2 (2)

187)

c. M&E efforts at local level?

2 (2)

188)

Comments and examples:

The M&E system is still the weakest components in the NAP. UNDP, through Global Fund financing, is expected to strengthen M&E system by having a National M&E plan in place and system strengthen. In additional there will capacity strengthening of the M&E personnel at the national and provincial level in the next 2 years. UN agencies have contributed towards enhancing capacity of the NAP staff and NGOs in programme delivery, reporting and recoding data. The Civil Society is still weak in M&E, they don't have the capacity to collect data in a standardized manner and analyze the information for dissemination.

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189) **Part B, Section II. CIVIL SOCIETY PARTICIPATION**

5. To what extent is the civil society sector representation in HIV efforts inclusive of diverse organizations (e.g. networks of people living with HIV, organizations of sex workers, faith-based organizations)?

1 (1)

190)

Comments and examples:

There are only few NGOs made by beneficiaries (drug users/ex drug users or families affected by drugs) No PLWHA NGOs or female sex workers and MSM NGOs

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191)

a. adequate financial support to implement its HIV activities?

2 (2)

192)

b. adequate technical support to implement its HIV activities?

3 (3)

193)

Comments and examples:

There are three major donors in the country: GF, UNICEF, UNODC Technical assistance is

provided by UNICEF and WHO. UNDP was the PR for GF funds.

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194) **Part B, Section II. CIVIL SOCIETY PARTICIPATION**

7. What percentage of the following HIV programmes/services is estimated to be provided by civil society?

Prevention for youth	25-50%
Prevention for most-at-risk-populations	
- Injecting drug users	51-75%
- Men who have sex with men - Sex workers	
Testing and Counselling	<25%
Reduction of Stigma and Discrimination	
Clinical services (ART/OI)*	>75%
Home-based care	
Programmes for OVC**	

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195)

Part B, Section II. CIVIL SOCIETY PARTICIPATION

Question 7 (continued)
Overall, how would you rate the efforts to increase civil society participation in 2009?

4 (4)

196)

Since 2007, what have been key achievements in this area:

• Strategic information collected through BBS with civil society participation 2008 • Interventions scaled up for DU with committed NGOs • Number of NGOs involved in planning and implementation has increased • Number of NGOs submitting proposals for funding increased as capacity built

197)

What are remaining challenges in this area:

• Lack of NGOs only working on HIV prevention targeting, DU/IDU and their families • Lack of NGOs working with MSM, CSW as yet • Lack of capacity among NGOs in designing interventions and implementation , monitoring and evaluation • Harm reduction programmes are not covering the all spectrum of interventions (condoms, needle and syringes exchange programme)

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198)

Part B, Section III: PREVENTION

1. Has the country identified the specific needs for HIV prevention programmes?

Yes (0)

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199)

Part B, Section III: PREVENTION

Question 1 (continued)
IF YES, how were these specific needs determined?

A rapid need assessment was done in the 2006, and this was followed by a BBS in 2008 to check the risk behaviours of the most of risk population and youth. A joint mid term review (JMTR) of the NAP/ National Strategic Plan (NSP) was conducted in 2009 which identified gaps and gave directions for strengthening and scaling up of the implementation of NSP 2007-2011.In addition it has been strongly suggested by the JMTR to do a size estimation and social mapping for the MARP. This has been taken into consideration and the process is already in progress.

200)

1.1 To what extent has HIV prevention been implemented?

	The majority of people in need have access
HIV prevention component	
Blood safety	Agree
Universal precautions in health care settings	Don't agree
Prevention of mother-to-child transmission of HIV	Don't agree
IEC* on risk reduction	Agree
IEC* on stigma and discrimination reduction	Don't agree
Condom promotion	Don't agree
HIV testing and counselling	Don't agree
Harm reduction for injecting drug users	Don't agree
Risk reduction for men who have sex with men	Don't agree
Risk reduction for sex workers	Don't agree
Reproductive health services including sexually transmitted infections prevention and treatment	Agree
School-based HIV education for young people	Don't agree
HIV prevention for out-of-school young people	Don't agree
HIV prevention in the workplace	Don't agree
Other: please specify	N/A

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201)

Part B, Section III: PREVENTION

Question 1.1 (continued)

Overall, how would you rate the efforts in the implementation of HIV prevention programmes in 2009?

4 (4)

202)

Since 2007, what have been key achievements in this area:

In 2008, the first Bio-Behavioural Survey (BBS) was conducted in the Maldives . A total of 1,791 serologic samples were taken across five groups: female sex workers (FSW), men who have sex with men (MSM), injecting drug users (IDU), occupational cohorts of men (OCM – including seafarers, construction workers and resort workers) and youth, across Male', Addu and Laamu atolls. Followed by the BBS, a qualitative research was conducted to get in-depth analysis of the trends and behaviours of the high risk groups. The outcome of these studies has formulated the BCC strategy which defines targeted intervention for these groups. The key intervention for the last two years were as follows: • Peer outreach for the DU and IDU in Male, Fuahmulak and Addu • HIV and STI awareness for migrant worker • Training and sensitizing of Law enforcement officers on MARPs vulnerability and HIV • Training of Health care providers on ST I ,VCT, HIV and Blood safety • HIV awareness among youth The BBS highlight alarming HIV and STI risky behaviour (sexual intercourses without protection as well as drug injecting by sharing needles and syringes) among population calling for action for prioritisation of the national response based on new evidence. Nearly all (98%) FSW in Addu and 88% in Male' reported unsafe sex with a client in the past 7 days; 100% and 80% reported unsafe sex with a regular partner in the past 7 days, indicating a clear potential pathway for HIV into sexual networks in which monetary exchange plays a role. MSM in Addu and Male' used condoms consistently in 21% and 36% of their encounters with men and in only 2% and 17% of their sexual encounters with women, respectively. Regarding sexual networking, IDU, similar to MSM, have a wide-ranging sexual network. In Addu and Male, 97% and 90% of IDU had sex in the past 12 months. 65% and 74% had a regular sex partner (of whom only 1% and 2% were also injecting); 54% and 55% had a non-regular partner, 52% and 38% bought sex; 4% and 16% sold sex; 2% of male IDU sold sex to another man in both locations and 1% and 2% of IDU reported consensual sex with another man. Importantly, 59% of IDU reported unsafe sex in the past 12 months. The mean age of debut of drug use of current injecting drug users was 16 in Male' and 17 in Addu. In both locations, the median age at which current IDU had shifted to injecting drugs was 22. A third (31%) of IDU in Male' and 23% in Addu reported sharing an unsterilized needle at the last time of injection. Cleaning of needles occurred but often using inappropriate and unsafe techniques. IDU In the last few years (2008-2009) prevention focusing drug users scaled up however focus mainly in Male' focusing on males. There is still a lack of services for female as well as for youth. Most of the detoxification services are exclusively for men, they don't address female, and youth clients needs. At the moment there are four centres (Drug Rehabilitation Centre in Himafushi-established in 1997; Regional Drug Rehabilitation Centre – established in 2005 which was closed in July 2009; two detoxification centres established in 2009) lead by the Government who provide services (treatment, physiological support, residential care, and religious support) for drug users or ex drug users. In 2009, the new Government launched their strategic action plan for the next 4 years that covers major issues related to drug use and HIV prevention in Maldives. Methadone Maintenance Treatment (MMT) centre opened in Male' by UNODC and the former National Narcotic Control Bureu (NNCB) was established in August 2008. Now, Department for Drug Prevention and Rehabilitation Services (DDPRS) - former National Narcotics Control Bureau is responsible for the monitoring and evaluating this activity, as Governmental institution. The MMT in Maldives was started as pilot programme, which has a maximum capacity of 60 clients and is supported by a psycho social programme. Journey works very closely with the MMT clinic in providing assistance to select clients for the programme as well as supporting the psychosocial programme. Past experience shows that the psycho social programme is lacking many required services and therefore is rather ineffective. Also, past experience shows MMT programme lacks leadership therefore is rather ineffective. As a result many clients on methadone are still abusing drugs frequently and aren't able to become more productive and self supportive. This area needs to be improved for the sustainability of the programme. In 2009, two new detoxification centres were

opened in Vilinghilli and Hulhu-Meedho Even if they don't have any rules and regulations in place the number of clients is increasing. In the last 3 years, Journey (NGO) has been providing after care services for drug users as well as for their family with support from UNICEF. Last year, Rajjee Foundation Maldives had came up with a partnership project between NGOs and the Government and extended the after care services. The project is coordinate by Journey as one of the most experience Maldivian NGO in drug prevention and rehabilitation area. Another 3 NGOs are involved in this project – Hand in Hand, SHE and SWAD. This project is a pilot project funded by American Embassy. Last year with the support from UNDP/GF, Journey opened a VCT Centre. They provide VCT service on site free of charge for all the clients interested in this service. As part of the aftercare project develop in partnership with the Government, all the NGOs involve in this project refer and promote Journey's VCTC for all their clients. Journey as well as SWAD is very actively engage also in advocacy for high level political leaders for promoting prevention programmes, care/support and treatment for drug users or recovery drug users. In prisons HIV/AIDS information disseminated to the prisons inmates through peers trained under the outreach programme for DUs and IDUs. 100% female inmates' population in Maafushi Prison (as of March 2009) and 84% of male inmates population in Maafushi Prison (as of March 2009) reached with HIV information. Blood safety No TT HIV reported in Maldives. All blood units are screened prior to transfusion and participate in external quality assurance system. PMTCT Sero prevalence of HIV among pregnant women and no reported cases of MTCT yet. 100% screening of pregnant women attending ANC services.

203)

What are remaining challenges in this area:

The 2 priority strategic areas of NSP, which are not addressed through GFATM round 6 and need attention are: • interventions for key populations • building capacity NAP . Taking into consideration the findings from 2008 BBS and mid term evaluation of the NAP recommendations, NAP will address these two strategic areas more in the second phase of the project funded by GFATM. Political commitment is needed to create an enabling environment for addressing most at risk populations. As BBS has shown, there is large number of MARP, very hidden and with high HIV risk behaviours. Comprehensive intervention for MARP is necessary, including condom promotions especially among young population. Increase VCT uptake among MARP as accessibility is an issue with the distribution MARP in several atolls./regions Comprehensive harm reduction programme for DUs are required based on the BBS findings. It is also very important to design and implement prevention and rehabilitation programmes for female affected by drugs (drug users, wives/partners of drug users, mothers of drug users). Another group who need to be address is youth. As mentioned in the MTR report youth is one of the groups who didn't benefited of effective intervention in the past. At present, the efforts of harm reduction are not harmonised and well-coordinated therefore a lot of duplication is there. Establish strong coordination among the implementers – government, NGOS and donors to prevent duplication of strategies, policies and services. Therefore there is an attempt to adhere to "3" one principle by having a common National M&E framework. Reporting systems of STIs (Syndromic management, need strengthening to capture early warning of an impending HIV epidemic). Syndromic management of STIS especially among MARP to be strengthened as there are no special STI clinics for MARP and a Policy decision on giving authorization to the community health workers for prescribing or dispensing drugs. A research among inmates is needed because there is a lack of information about the HIV situation in prisons. Based on the research's findings NAP can design and implement appropriate intervention for this population.

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204)

Part B, Section IV: TREATMENT, CARE AND SUPPORT

1. Has the country identified the specific needs for HIV treatment, care and support

services?

No (0)

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205)

IF NO, how are HIV treatment, care and support services being scaled-up?

Currently only 3 are on treatment since ART program was commenced in 2004. ART is provided in a single centre, and no specific care and support systems planned. Due to the low prevalence, scaling up is not planned at this stage.

206)

1.1 To what extent have the following HIV treatment, care and support services been implemented?

	The majority of people in need have access
HIV treatment, care and support service	
Antiretroviral therapy	Agree
Nutritional care	Don't agree
Paediatric AIDS treatment	N/A
Sexually transmitted infection management	Don't agree
Psychosocial support for people living with HIV and their families	Don't agree
Home-based care	Don't agree
Palliative care and treatment of common HIV-related infections	Agree
HIV testing and counselling for TB patients	Don't agree
TB screening for HIV-infected people	Agree
TB preventive therapy for HIV-infected people	Don't agree
TB infection control in HIV treatment and care facilities	Don't agree
Cotrimoxazole prophylaxis in HIV-infected people	Agree
Post-exposure prophylaxis (e.g. occupational exposures to HIV, rape)	Don't agree
HIV treatment services in the workplace or treatment referral systems through the workplace	N/A
HIV care and support in the workplace (including alternative working arrangements)	N/A
Other: please specify	

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207)

Part B, Section IV: TREATMENT, CARE AND SUPPORT

Question 1.1 (continued)
Overall, how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2009?

7 (7)

208)

What are remaining challenges in this area:

To optimize utilisation of the VCT centres in public (8 at present) and 2 stand alone VCT centres (Majority of HIV tests were for PIT and for pre-employment screening, blood donor screening or pre-surgical screening). The majority HIV testing takes place as a mandatory one, and without counselling (pre or post or both are lacking). Of those tested, the most at risk populations are almost negligible.

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209)

Part B, Section IV: TREATMENT, CARE AND SUPPORT

2. Does the country have a policy or strategy to address the additional HIV-related needs of orphans and other vulnerable children?

N/A (0)